STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Hills Nursing and Rehabilitation Center	1016 Fletcher Street Wilkesboro, NC 28697

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews with residents, facility staff, the Nurse Practitioner, and Psychiatric Provider, the facility failed to protect the resident's right to be free from resident-to-resident abuse for 1 of 3 residents reviewed for abuse (Resident #2) on 4/30/26. Resident #2 sustained a left hip fracture and a left olecranon (elbow) fracture. The findings included: Resident #3 was admitted to the facility on [DATE]. Diagnosis included Alzheimer's disease, dementia, and anxiety. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #3 was severely cognitively impaired and required substantial assistance for toileting, dressing and showers. Resident #1 was admitted to the facility on [DATE]. Diagnosis included a fall with traumatic brain injury (TBI), Paranoid Schizophrenia and dementia. Review of annual MDS dated [DATE] revealed Resident #1 was severely cognitively impaired, independent for mobility, required moderate assistance with toileting and bathing. Resident #1 was coded for wandering and behaviors. Review of the Facility Reported Incident dated 4/17/26 revealed that Resident #1 and Resident #3 were at the nurse's station when Resident #3 told Resident #1 to shut up and Resident #1 pushed Resident #3 down. Facility staff intervened and separated the two residents. Resident #3 was assessed by the nurse and was found to have no injuries, and he did not have any complaints of pain at the time of the altercation. Resident #1 was put on 1:1 supervision (a staff member stays with the resident 24 hours a day, 7 days a week) for the rest of the shift and was assessed by the Psychiatric Provider within hours of the altercation. His trazodone (a medication used for depression) was restarted at 50 milligrams three times a day as needed for anxiety. According to the report the Psychiatric Provider determined that it would be okay to remove the 1:1 supervision and put Resident #1 on every 30 minute checks for aggression. An interview was conducted with the Psychiatric Provider on 5/26/26 at 4:00 PM. She reported that Resident #3 had exhibited behaviors in the past of wandering and increased anxiousness with wanting to leave. She reported he was usually easily redirected and his as needed anxiety medications were effective. She reported she did not recall any aggressive behavior from Resident #3. The Psychiatric Provider reported that Resident #1 had a history of verbal aggression toward staff and residents and was impulsive in behavior. The Psychiatric Provider reported that she was aware of the incident that occurred on 4/17/26. She stated that during this incident, Resident #1 became physically aggressive with Resident #3, pushing Resident #3 to the floor after Resident #3 told Resident #1 to shut up. After this incident the Psychiatric Provider reported that she restarted Resident #1's Trazodone. She reported that the facility put him on 1:1 supervision for the remainder of the shift after this incident and she recommended that the 1:1 supervision be discontinued and he be moved to every 30 minute checks. She reported at this time, she felt this was in the best interest of Resident #1 as well as the other residents because Resident #1's trazodone was effective and because of his diagnosis of paranoid schizophrenia, having someone following him could make his symptoms and outburst worseAn interview was conducted with the NP on 5/26/26 at 2:58 PM. The NP stated that Resident #1 could be aggressive both verbally and physically aggressive. She reported she was aware of the incident that occurred between Resident #1 and Resident #3. She (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	revealed that Resident #1 had been placed on 1:1 supervision after the incident with Resident #3 for a short time. She stated that when Resident #1 was on 1:1 supervision he was more easily agitated. She reported that Resident #3 did not have any injuries from the incident on 4/17/26.An interview was conducted with the Director of Nursing (DON) on 5/26/26 at 3:02 PM. She reported that on 4/17/26 Resident #1 and Resident #3 were at the nurse's station. Resident #3 told Resident #1 to shut up and Resident #1 pushed Resident #3 down. The DON stated Resident #3 did not have any injuries from the fall and Resident #1 was placed on 1:1 supervision for the remainder of the shift and then put on every 30-minute checks per direction of the Psychiatric Provider. She reported that the Psychiatric Provider also restarted his Trazodone and it was effective.An interview was conducted with the Administrator on 5/26/26 at 4:15 PM. He reported he was made aware of the incident on 4/17/26 between Resident #1 and Resident #3. He stated an investigation was conducted and no abuse was found. Prior to this incident neither resident had been physically aggressive with anyone in the facility. Resident #2 was admitted to the facility on [DATE]. Diagnosis included right hip fracture, dementia and alcohol abuse. Review of the quarterly MDS dated [DATE] showed Resident #2 was severely cognitively impaired, was coded for wandering and behaviors. He was independent with mobility and required moderate assistance with bathing. Review of the Facility Reported Incident dated 4/30/26 revealed Resident #1 and Resident #2 were at the nurse's station. Resident #1 was yelling at the nursing staff about his remote control being broken. Resident #2 told him to stop yelling at the girls and Resident #1 hit Resident #2 in the left side of the face, knocking him to the ground. The incident was witnessed by Nurse #1. According to the investigation, Nurse #1 was walking down the hall when she heard Resident #2 and Resident #1 verbally attacking one another, she turned around to see Resident #1 hit Resident #2 in the face. She returned to the nurse's station to intervene. The report indicated that Resident #1 immediately returned to his room and Resident #2 was assessed by Nurse #1 and was assisted to a chair by Nurse #1 and Nurse Aide (NA) #1. At the time of the incident Resident #2 complained of burning in his right hip. There were not any abnormalities of his upper or lower extremities noted at the time of the incident. The report noted that the Resident #2 sat at the nurse's station eating snacks and drinking a soda for a good portion of the evening after the incident. The report indicated that Resident #2 was put on 1:1 supervision during this time because staff felt like he was the perpetrator. The investigation revealed that on 5/1/26 around 7:45 am Nurse #2 reported Resident #2 was complaining of pain in his hips, and her assessment revealed that he had a swollen left elbow and his left leg was rotated outwards and was shorter than the right. Nurse #2 notified the NP, who was in the facility at the time. The NP assessed the resident as well and gave orders to give him Norco (an opioid prescription pain reliever) and send him to the emergency room (ER) for evaluation. Review of 5/1/26 hospital records revealed a left olecranon fracture which required a posterior slab splint (a rigid device used to immobilize the elbow) to be placed. This procedure was noted to be done at bedside with no complaints from Resident #2. Hospital records also revealed a left hip fracture, which required total hip arthroplasty (a surgical procedure where a damaged hip joint is removed and replaced with an artificial prosthetic implant). Hospital records reported that Resident #2 tolerated the surgery well with minimal complaints of pain and was discharged back to the facility in good condition. An interview with the Psychiatric Provider was conducted on 5/26/26. She reported that she was aware of the incident between Resident #1 and Resident #2. She stated that Resident #2 had a long history of being rude towards staff, which had caused problems with his care and the facility had made a lot of medications changes to help with his anxiety and outbursts. She stated that Resident #2 gave no warning signs before his outburst and therefore as needed medications could be difficult to manage with him. The Psychiatric Provider reported Resident #2's outburst and aggression had been verbal in nature, and mostly towards staff but occasionally he had said some things that were inflammatory towards other residents. She reported she did not recall any physical aggression towards staff or other residents from Resident #2. She reported that Resident #1 had a history of verbal aggression toward staff and residents and was (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	impulsive in behavior. The Psychiatric Provider reported she had done a telehealth visit with Resident #1 the day after this incident and he could not remember anything that had happened. She reported that the facility had initially put Resident #2 on 1:1 supervision but due to this being the second physical aggression incident towards a resident for Resident #1 they put him on 1:1 supervision for his safety as well as the safety of the other residents. The Psychiatric Provider reported she agreed with the 1:1 supervision at this time for the safety of Resident #1 and the other residents. She reported she was monitoring Resident #1 closely for any increased anxiety and/or behaviors due to the 1:1 supervision.An interview with Nurse #1 was conducted on 5/26/26 at 7:30PM. Nurse #1 reported she was working on 4/30/26 when the incident occurred between Resident #1 and Resident #2. She stated Resident #1 and Resident #2 were at the nurse's station. Nurse #1 revealed Resident #1 was at the nurse's station to report his remote control was broken again, even though staff had shown him several times that it was working. Nurse #1 reported she was called down the hall to assist with another resident. She stated when she walked away from the nurse's station, Resident #1 and Resident #2 were both just standing at the nurse's station and were not arguing. Nurse #1 stated that she got about three quarters of the way down the hall and heard Resident #2 raise his voice, although she could not understand what he said. Nurse #1 reported she turned around and saw Resident #1 punch Resident #2 in the left jaw and Resident #2 fell to the floor. Nurse #1 stated she immediately went to Resident #2 and assessed him. She reported that Resident #1 walked off to his room. Nurse #1 reported that Resident #2 didn't remember that he had been hit and reported that his right hip was burning. She stated this was not a new complaint of pain for him. Nurse #1 stated that she did not note any external rotation of either leg, no swelling in either legs or arms at the time of her assessment. She stated that after her assessment she felt it was safe to move him to a chair. She reported she gave his ordered Tylenol and called the medical provider on call to report the incident. The provider ordered a right hip x-ray. Nurse #1 stated she also put Resident #2 on 1:1 supervision because she felt he was more the aggressor than Resident #1. Nurse #1 reported that after the incident Resident #2 stayed at the nurse's station eating snacks. Nurse #1 stated that NA #1 laid him down, upon his request, sometime between 3:30 AM and 5:00 AM. Nurse #1 reported she was not made aware of any concerns when Resident #2 was laid down, and no distress was noted on her shift. Nurse #1 stated she checked on Resident #2 again around 6:30 AM before her shift ended and he was sleeping on his left side.An interview was conducted with the Director of Nursing (DON) on 5/26/26 at 3:02 PM. She reported that she was called around 8:45 PM on 4/30/26 by Nurse #1 who reported the Resident-to-Resident altercation between Resident #1 and Resident #2. The DON reported that when she arrived at the facility on 4/30/26 at around 9:45 PM, Resident #2 was sitting at the nurse's station in a Broda chair (a recliner type chair) eating a snack. She reported that Nurse #1 had assessed both residents and only some puffiness was noted on Resident #2's left cheek and Resident #1 had no injuries and no complaints of pain. The DON stated that during her assessment Resident #1 was in his room, watching TV and had no complaints of pain and did not remember what had occurred. The DON reported she assessed Resident #2 and did not note any injuries at the time of her assessment, he was also not complaining of pain. The DON reported that staff had placed Resident #2 on 1:1 supervision, as they felt he was the aggressor during this incident. However, after the investigation the facility with the guidance of the Psychiatric Provider determined that Resident #1 would be put on 1:1 supervision since this was his second incident of physical aggression towards a resident. The DON stated that Resident #1 and Resident #2 had not had any problems with one another in the past.An interview was conducted with the Administrator on 5/26/26 at 4:15 PM. He reported he was made aware of the incident on 4/30/26 between Resident #1 and Resident #2. He reported that an investigation was conducted and no abuse was found. He stated that Resident #1 had been aggressive in the past but had been doing well on his current medication regimen and the staff felt he was settling into a routine at the facility. The Administrator reported he felt like this incident was unexpected due to the improvement in Resident #1's recent behaviors.Facility provided the below (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	corrective action plan on 5/27/26:Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 is [AGE] years old, with diagnoses of Traumatic subdural hemorrhage, Paranoid Schizophrenia, Epilepsy, Unspecified dementia severe with other behavioral disturbances, and resided on the dementia unit.Resident #2 is [AGE] years old, with diagnoses of Dementia, Psychotic disturbance, Chronic pain, Anxiety, History of alcoholism and resided on the dementia unit.On 04/30/2026 approximately 8:30 pm, Resident #1 and Resident #2 were observed by Nurse #1 standing at the nursing station having a conversation. No behaviors or signs of agitation were noted at that time. Nurse #1 stepped away from the nurse's station desk and had walked about 45 feet when she heard bickering. Nurse #1 reported Resident #2 could be heard talking loudly. It was unclear what the residents were saying. When Nurse #1 turned around, she observed Resident #1 hit Resident #2 on the left side of his cheek. Resident #2 lost his balance falling backwards onto the floor. Nurse #1 and nursing assistant #1 intervened immediately by separating residents. Resident #1 returned to his room. Resident #2 was taken to the dining room and placed 1:1 observation.On 4/30/26, Resident #1 and Resident #2 were immediately assessed during the 3-11 shift after the incident. Resident #1 had no injuries or reports of pain noted. Resident #2 complained of a burning sensation in his right hip and puffiness noted on the left side of his cheek below his eye. The nurse notified the provider after becoming aware of the burning sensation in the resident's right hip. A new order was received for an X-ray of the right hip. On 4/30/26, at approximately 8:30 pm, Nurse #1 notified the provider and the Director of Nursing of the incident. Nurse #1 attempted to notify Resident #1 and Resident #2 representative but was unsuccessful. On 4/30/26, skin checks and pain assessments were completed by the nurse on both residents at which time the puffiness around Resident #2's eye had resolved.During the remainder of the 3-11 shift and 11-7 shift, per staff interviews including the 1:1 sitter, staff noted no changes in condition during care.On 5/1/26 at approximately 7:15 am, during care, Resident #2 complained of pain to bilateral hips and left elbow. Nurse #2 assessed Resident #2 and observed left elbow was edematous from the left upper arm extending to the left lower arm and a dark blue circular discoloration noted on the left elbow. The left leg was noted to be shorter than the right leg with slight external rotation. Resident #2 was wincing with movement. The supervisor and medical provider were immediately notified by Nurse #2. Pain medication was administered. The medical provider was on site at the facility and assessed Resident #2 with new orders received to send to the emergency room for further evaluation.On 5/1/26, a telehealth visit by psychiatric services was completed for Resident #1. Trazodone as needed was restarted.On 5/1/26, Resident #2 was found to have a closed left olecranon fracture and left femoral neck fracture per hospital records with surgical repair. On 5/1/26, Resident #1 was placed on 1:1 observation and continues to remain on 1:1 observation.On 5/6/26, Resident #2 returned to the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.On 4/30/2026, 100% skin checks were initiated on all residents residing in the dementia unit. The skin checks were conducted by the Director of Nursing, the Quality Assurance nurse, and the assigned hall nurse for signs and symptoms of abuse. No concerns were identified during this audit. The skin checks were completed by 5/1/26. On 5/1/26, 100% skin checks were expanded and initiated on all residents residing in the remaining facility, with a brief interview for mental status (BIMS) of 12 and below. The skin checks were conducted by the Director of Nursing, the Quality Assurance nurse, and the assigned hall nurse for signs and symptoms of abuse. No concerns were identified during this audit. The skin checks were completed by 5/6/26. On 5/1/2026, the Director of Nursing audited 100% of all residents' progress notes and behavior alerts in the Point of Care electronic medical record to identify behaviors that occurred in the last 14 days to ensure interventions were in place and documented in the care plan. The audit was completed on 5/1/2026. No concerns were identified during the audit. On 5/1/2026, the Director of Nursing, Assistant Director of Nursing, and Nurse Managers initiated interviews with all staff to identify residents with behaviors. The purpose of the audit was to ensure (1) the behaviors were reflected in (continued on next page)

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